No sign of the new dawn

Pharmacy policy is in a mess. There has been too much of the 'vision thing' and not enough focus on the here and now, suggests Dr Darrin Baines, director of MedM

Pharmacy policy is in a mess. On the one hand, the vision for the future, carefully prepared and sold by the profession's leaders, is not living up to expectations. On the other, panicky pharmacy politicians are blaming the Government for undermining the foundations of the profession by allowing the OFT to investigate contract limitation and the Department of Health to cut the dispensing fee.

In recent years, those at the top have spent too much time dreaming about the future and have not put enough effort into protecting the *status quo*. It is hardly surprising that problems now keep cropping up. For example, the dispensing fee was cut not because ministers and civil servants were unfair or unlawful, but because pharmacy representatives have not sold community pharmacy's benefits effectively – or at least had not until RPM reared its head.

The DoH needs ammunition to fight off the Treasury and the national organisations have not worked hard or long enough to persuade ministers and civil servants to prepare a stronger case for more money.

If individual leaders had been able to spend more time working on a case for extra cash, instead of dealing with internal politics, contractors might currently be celebrating a fee rise, instead of the worst cut in revenues in the profession's history.

When the facts are analysed from an outsider's perspective, pharmacy's leadership probably has more to answer for in the growing crisis than the Government.

To add to the gloom, the plans laid by the Society *et al* to reform pharmacy practice seem to be failing because they have been overtaken by unforeseen events.

Most notably, the NHS has moved on significantly since the mid-1990s when the major pharmacy bodies began to develop blueprint for new roles for the profession under the *Pharmacy In A New Age* (PIANA) banner. NHS managers and Labour politicians are now more concerned with introducing clinical governance, primary care trusts and one-stop primary care centres than extending the roles currently undertaken by hospital or community pharmacists.

In this new environment some groups not traditionally linked with the profession are stealing a march. For instance, the National Prescribing Centre until recently monopolised the medicines management agenda, while the joint pharmacy pilot (run by the PSNC) was stuck awaiting ethics committee approval.

Similarly, the recent Audit Commission report, *A Spoonful of Sugar* (published in December 2001) outlines a well-researched vision for the future of medicines management in secondary care, which puts the efforts made by pharmacy bodies to shame.

The profession's leaders face a dilemma – push ahead with the reforms on which they staked their reputations, or retrench and concentrate on protecting the existing network of pharmacies while it is still possible?

Although questions have been asked about the future of pharmacy since the NHS began, the current push for major reform began with the publication of the *Nuffield Report* in 1986 which suggested that:

- pharmacists should remain in "personal contact" with their premises
- guidelines should clarify whether pharmacists should dispense every item
- the remuneration system for pharmacists should be changed
- a limit should be placed on the number of pharmacy outlets.

"By setting aside the past, have the profession's leaders made a strategic mistake?"

The *Nuffield Report* stimulated the RPSGB to launch the PIANA process, which began in 1995 with discussions regarding the reform of the profession.

Council of the RPSGB distilled the findings of its research – along with its own vision for the future – in *The New Horizon*, published in 1996.

Although the PIANA process was criticised for involving too many academics and enthusiasts and too few working pharmacists, the reform agenda had been set in motion and forward-looking members of the profession had been encouraged to join ranks.

As the PIANA momentum developed, the RPSGB launched its strategy for innovating community pharmacy, *Building the Future*, in September 1997, four months after Tony Blair was elected.

Building the Future suggested that pharmacists could make their greatest contribution by managing medicines, long-term conditions and common ailments. Gains could also be made if they promoted healthy lifestyles and provided advice to other healthcare professionals.

From a management perspective, *Building the Future* is an interesting document as it seems implicitly based upon the unorthodox views of the management prophet, Charles Handy, whose thoughts on development and change were quoted on p3 of the document: "We must not let our past, however glorious, get in the way of our future."

Against a background of recession and companies "downsizing" their workforces, during the 1990s, Mr Handy reported that the future for business could be explained by t equation: 1/2 x 2 x 3.

This equation predicted that, years to come, half as many peo would be employed, working tw as efficiently, producing three times as much.

As a result, Mr Handy suggested that by 2000, half the working population would not full-time employees but would living "portfolio" lives, "mixin different bits and pieces of wor some for money, some for fun, some for free", while continual re-educating themselves just t stay in business.

Applied to community pharmacy, Mr Handy's logic suggested that fewer pharmaci would be doing more work, wl spending up to 10 per cent of lives studying to keep pace wit changes. But his ideas don't ap to traditional community pharmacy.

During the mid-1990s, Mr Handy analysed major compa with substantial workforces, w were buckling under the coml pressures of recession and changing work patterns.

At the time, none of these pressures applied to commun pharmacies. Public funding protected their incomes, and were usually small businesses without large workforces to downsize. Moreover, individu pharmacists could not adopt portfolio working, as supervision regulations proh

RPSGB Council's vision for the future has encouraged forward-looking members of the profession to join ranks

them from leaving their shops.

Therefore, Mr Handy's theories on securing change could only be applied to community pharmacy once its stability and established working practices had been destroyed. So the RPSGB decided to back some changes which would undermine that stability.

The timing of *Building the Future* was unfortunate. The strategy document appeared too late to influence policy before the publication of the new *NHS White Paper* in December 1997. So, pharmacists were initially excluded from many of the initiatives.

More importantly, the strategy appeared out of touch with Tony Blair's vision for the NHS. When the conclusions of PIANA were submitted to the then health secretary Frank Dobson, the DoH could not respond until they had been redrafted in line with the Government's plans.

While Mr Blair's vision for the NHS left many pharmacy leaders struggling to catch up, three recent developments in Government policy question the appropriateness of many of the roles currently performed by the profession's national bodies.

First, the Government's desire to overhaul the NHS doesn't primarily include community pharmacy. It is not seen by voters as a problem area.

The Government has, however, picked up on the fact that the profession has an under-utilised set of skills, and it now has a wider agenda for pharmacy. But it also has bigger issues to resolve – any special pleading from the profession will always be heard in the context of winning votes, controlling public expenditure or promoting increased competition.

Furthermore, Tony Blair has continued the process of dividing the Government into autonomous units, with the result that pharmacy's leadership must now negotiate with a diverse group of official bodies, if they can.

Consequently, contract limitation can be investigated and the dispensing fee cut by people that pharmacy's leaders don't normally meet, with whom they have no special relationships or rights of access. This greatly reduces the national bodies' ability to protect or to promote pharmacy's position.

Finally, the funds for remunerating pharmacists may soon be devolved to primary care trusts, and new payment arrangements introduced under the local pharmaceutical services pilot scheme. The result will be that fewer pharmacists will be paid under the national dispensing fee.

If such a situation arises, pharmacies will be free to negotiate their own futures, making national representation and one ideology for the whole of the profession increasingly difficult to hold together.

However, by setting aside the past, have the profession's leaders made a strategic mistake? Did they anticipate that the process of change is in itself unpredictable?

For example, you cannot continually preach that community pharmacy needs to radically change while ignoring the fact that this also implies the dispensing fee or contract limitation should alter.

There may soon be fewer pharmacists doing more work for less money, without the freedom needed to walk away from the dispensary to do something more interesting and lucrative instead.

As the profession moves further into the change process, growing unease among working pharmacists may cause trouble at the top. It is not good at this point for leaders to try to make ministers and civil servants the scapegoats for the profession's woes.

However, pharmacists can console themselves by dreaming that the introduction of PCTs will lead to the re-structuring of the national pharmacy bodies, as local contract negotiations make these organisations ideal candidates for the application of Mr Handy's 1/2 x 2 x 3 rule.

National pharmacy policy's 10 worst failures

1. Failure to stick to core business
Many of pharmacy's national bodies have not stuck to their traditional core roles in recent years, leading to a failure to defend existing ground (for example, the dispensing fee) while new initiatives have not yet borne fruit (for instance, medicines management pilots).

2. Creation of conflict of interest
National bodies have created a major conflict of interest by championing a new agenda for their members, which has severely limited their ability to defend the profession's existing position. For example, the money secured for the PSNC-run medicines management project makes it difficult to negotiate with the Government over the dispensing fee, unless the project is closed and the money is given back.

3. Failure to support community pharmacy
While most of pharmacy's leaders got excited about the future, they forgot that community pharmacy is the profession's main power base. Without a strong network of local pharmacies, pharmacists will wander around the NHS without a home and its professional leaders will be increasingly marginalised within the new NHS.

4. No new remuneration system 15 years after Nuffield
Amazingly, over 15 years since the *Nuffield Report* recommended a new payment system for community pharmacy, the profession's leaders still do not have a coherent plan for replacing the dispensing fee, which suggests they haven't got a clue about how to design new incentives for this type of business.

5. Failure to differentiate pharmacy providers
Local pharmaceutical committees must have representatives of different types of pharmacies on their committees – from retail chains to independents – but national negotiations still treat all pharmacies the same, which is nonsense as a negotiating position, as retail chains have different cost structures to independents.

6. Failure to understand evolving structure of government
The Government has become increasingly complicated, especially in recent years, with different departments pursuing competing objectives, often without communication with each other. Despite this, many of pharmacy's leaders still tell the rank-and-file that the Government provides a unified, single threat.

7. Failure to respond to the new primary care agenda
The new power base in the NHS lies within primary care organisations run by doctors. Pharmacy bodies were slow to respond to this important development, particularly in getting representation on primary care trusts or securing extra funding from the NHS Modernisation fund.

8. Failure to respond to the introduction of one-stop centres
At present, one-stop primary care centres, which must have a pharmacy, are the biggest threat to individual contractors – a threat the national bodies have not stopped. The best response the national bodies seem able to offer to this development (that will bankrupt some contractors) is the recommendation that local contractors form consortia to run services in these bodies.

9. Indecision over the profession's monopoly position
Many pharmacy leaders are not clear whether a monopoly over supervision stifles professional development or protects the profession's funding and position, which effectively stops the extension of professional roles and the growth in the appropriate use of technicians and dispensing assistants.

10. Failure to stimulate debate over LPS pilots
In any other profession, the introduction of LPS pilots would have stimulated widespread, heated debate – but not in pharmacy, where some national bodies advised against discussion until after their launch!